PATIENT QUESTIONNAIRE

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

In what state were you born? _____

Pharmacy Name: _____
Address: _____
Phone Number: _____

Please answer all questions to the best of your ability. Check all questions asking for "yes" or "no" answer appropriately, but eave blank if you are not sure.

A. GENERAL HEALTH: (Circle) Excellent Good Fair Poor

B. PAST MEDICAL HISTORY:

Medical Illnesses	*Yes*	*No*	*Year*	*Complications/Comments*
Blood Disorders				
Cancer				
Diabetes				
Emotional Disorder				
Heart Disease				
Hepatitis B				
Hepatitis C				
High Blood Pressure				
HIV				
Kidney Disease				
Liver Disease				
Neurologic Disorder				
Pneumonia				
Rheumatic Fever				
Skin Disease				
Tuberculosis				

Other Illnesses and/or Surgery: Please list illness or surgery, year, any complications and any hospitalizations

	Year	*Complications*	*Comments*

Injuries: (List all significant injuries which you recall either in childhood or adult life with approximate date and complications)

	Year	*Complications*	*Comments*

IMMUNIZATIONS:

Vaccine	Yes	No	Year
Influenza			
Pneumonia			
Polio			
Small Pox			
Tetanus			
Other (Specify)			

ALLERGIES: (List all drugs or substances to which you are allergic and specify type of reactions, i.e., itching, rash, hives, wheezing, swelling, etc.)

If you have no known allergies, please check here ☐

DRUG/SUBSTANCE	ALLERGIC REACTION

HABITS:

Habit	Yes	No	How Much (Per day/per week)
Alcohol			
Cigarettes			
Cigars			
Drugs (Specify)			
Pipe			
Do you wear seatbelts?			

MEDICATIONS:

(List all medications which you take regularly, including over-the-counter, medications, vitamins, herbal supplements, etc)

Name of Medication	Amount Per Day	Strength (dose)

C. FAMILY HISTORY:

Have any **relatives** had the following illnesses: (Please specify maternal or paternal)

ILLNESS	YES	NO	If yes (what relation)	COMMENTS
Arthritis or rheumatism				
Cancer				
Goiter				
Hardening of the arteries				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Seizures				
Strokes				
Tuberculosis				
Venereal Disease				

D. REVIEW OF SYSTEMS:

Please check "yes" or "no" as deemed appropriate regarding the following symptoms. If you are not sure, leave blank. Leave "Comments" blank.

Yes	No	GENERAL	COMMENTS
		Weakness	
		Tiredness	
		Lack of Appetite	
		Excess Appetite	
		Weight Loss	
		Weight Gain	
		Chills	
		Fever	
		Night Sweats	
		Difficulty Sleeping	

YES	NO	SKIN	COMMENTS
		Dryness of skin	
		Itching	
		Rash	
		Change in skin color	
		Change in texture of hair	
		Falling out of hair	
		Nail Changes	
		Skin ulcers	

YES	NO	EYES, EARS, NOSE, THROAT	COMMENTS
		Decreased ability to see	
		Blurred vision	
		Spots before your eyes	
		Pain in the eyes	
		Infection in the eyes	
		Difficulty in hearing	
		Ringing in your ears	
		Pain in your ears	
		Discharge from the ears	
		Nosebleeds	

YES	NO	EYES, EARS, NOSE, THROAT	COMMENTS
		Running of the nose	
		Stuffiness of the nose	
		Sneezing	
		Post-nasal drip	
		Sinus trouble	
		Hay fever	
		Sore throat	
		Hoarseness	
		Pain in the neck	
		Dental trouble	
		Bleeding gums	

YES	NO	RESPIRATORY	COMMENTS
		Dry cough	
		Coughing up phlegm	
		Coughing up blood	
		Wheezing	
		Shortness of breath at rest	
		Shortness of breath w/exertion	
		Pain in chest when coughing sneezing or moving	

YES	NO	BREASTS	COMMENTS
		Lump	
		Pain	
		Discharge	

YES	NO	CARDIOVASCULAR	COMMENTS
		Chest pain, tightness or squeezing	
		Shortness of breath lying down	
		Need to sit up to breathe	
		Heart racing	
		Irregular heartbeat (palpitations)	
		Heart murmur	
		Swelling of the legs	
		Varicose veins	
		Leg pain at rest	
		Leg pain with exertion	
		Blue or purple discoloration of hands or feet	

YES	NO	GASTROINTESTINAL	COMMENTS
		Nausea	
		Vomiting	
		Diarrhea	
		Constipation	
		Heartburn	
		Abdominal pain	
		Bright red blood in stools	
		Black stools	
		Change in bowel habits	
		Food intolerance	
		Need for antacids	
		Hemorrhoids	

YES	NO	MUSCULOSKELETAL	COMMENTS
		Painful joints	
		Swelling of any joints?	
		Redness of any joints?	
		Stiffness of any joints?	
		Deformities of the joints or extremities?	
		Muscle pain?	
		Back pain?	
		Pain down the back of legs?	

YES	NO	URINARY	COMMENTS
		Urinary tract infections	
		Pain or burning on urination	
		Frequent urination – day	
		Frequent urination - night	
		Unusually large volumes of urine	
		Extreme urge to urinate	
		Difficulty starting urinary stream	
		Difficulty stopping urinary stream	
		Kidney stones	

YES	NO	GENITO-REPRODUCTIVE (Male)	COMMENTS
		History of venereal disease	
		Discharge from penis	
		Testicular pain	
		Lumps in testicles or scrotum	
		Decreased sexual drive	
		Decreased ability to achieve erection	

YES	NO	GENITO-REPRODUCTIVE (Female)	COMMENTS
		Age of onset of menstrual periods	
		Age when periods stopped (menopause)	
		How far apart are your periods?	
		Is flow heavy, scanty or normal?	
		Do you ever bleed between periods?	
		Do you ever have to go to bed because of cramps?	
		What was the date of your last normal period?	
		What was the date of the period before that?	
		Do you ever have heavy vaginal discharge?	
		Have you ever had any venereal disease? If yes, what kind?	
		Does intercourse cause undue pain?	
		Do you have decreased sexual desire?	

		Have you had any vaginal bleeding since menopause?	
		Are you bothered by hot flashes?	
		Are you taking any female hormones?	
		What form of birth control do you use?	

	NUMBER	NONE	COMMENTS
Full term deliveries			
Miscarriages			
Stillbirths			
Complications:			
High blood pressure			
Toxemia			
Severe hemorrhage			
Children over 9 lbs at birth			
Other (specify)			

YES	NO	NEUROLOGICAL/PSYCHIATRIC	COMMENTS
		Nervousness	
		Depression	
		Difficulty going to sleep	
		Early morning awakening	
		Difficulty with memory for past events	
		Difficulty with thinking or problem solving	
		Headaches	
		Blackouts	
		Dizziness	
		Double vision	
		Paralysis/weakness of limb(s)	
		Loss of sensation	
		Loss of balance	
		Loss of coordination	
		Difficulty in speaking	

YES	NO	ENDOCRINE	COMMENTS
		Goiter	
		Heat intolerance	
		Cold intolerance	
		Tremulousness of hands	
		Change in pitch of voice	
		Increased body hair (face, underarms or pubic)	
		Decreased body hair (face, underarms or pubic)	
		Decrease in breast size	
		Loss of periods (disregard if from normal menopause)	
		Increased thirst	
		Increased urination	
		Marked increase in appetite	